Michigan Department of Community Health

MDCH

Application to be a Yellow Fever Immunization Provider

Please PRINT or TYPE Requested Information.

Clinic Name: _____

Contact Person: _____
First Name Last Name Title

Contact Person's e-mail address: _____

Supervising Physician: _____
First Name M.I. Last Name Degree

Physician's State of Michigan License #: _____

Physician's DEA #: _____

Clinic Address: _____
Street City Zip Code County

Clinic Phone No: _____/_____ Fax No: ____/_____

Days Clinic Open: (Check all that apply) ☐ Su ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ S

Clinic Hours: _____ A.M. _____ P.M. Open to the Public? ☐ Yes ☐ No

Appointments required: ☐ Yes ☐ No Website address: _____

Services to be provided:
- ☐ General travel immunizations (i.e., hepatitis, MMR, Td)
- ☐ Yellow Fever vaccine
- ☐ Other services (please describe)

Must submit ➔ **Please attach a narrative description of the supervising physician's experience in providing travel immunizations and their reason(s) for applying to be a travel immunization/yellow fever vaccine provider.**

_____ _____
Supervising Physician's Signature Date

RETURN THIS FORM TO:
MDCH – Division of Immunization
201 Townsend St.
PO Box 30195
Lansing MI 48909